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Acupuncture & Herbal Medicine
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Confidential Patient Health History

Patient's name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Height: _____ Weight: _____

Relationship status: Single __ Married __ Divorced __ Widowed __ Living w/ Partner __ Other __

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail (we will not share it) _____

How would you prefer to receive appointment reminders? _____

Emergency Contact Name _____ Phone Number _____

Relationship: Spouse / Partner / Parent / Other

Referred by _____

Are you currently under the care of a physician? ____ If yes, who? _____

Date of last visit? _____ Purpose of visit: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you!

Have you had Acupuncture? Yes or No Chinese Herbal Medicine Yes or No

Please identify the health concerns that have brought you here today, in order of importance below:

Condition	Past Treatment
a. _____	_____
How does this condition affect you?	_____
b. _____	_____
How does this condition affect you?	_____
c. _____	_____
How does this condition affect you?	_____

Please list any foods, medications or herbs/supplements you are allergic to or have an adverse reaction to (please include reaction): _____

_____

Please list ALL vitamin supplements, prescribed and over-the-counter medications, herbs, oils, etc.

What you are taking?	**Prescribed by?**	**Dosage**	**Condition being treated?**
Sample: Vitamin D3	*Primary, Self*	*2,000 iu 1x/day*	*Low level on labs*

Please list all prior hospitalizations, surgeries and serious medical events.

Year	**Surgery/Illness**	**Reason**

Please put a "C" for a current condition or a "P" if you had the condition in the past.

General

___ Insomnia
___ Nightmares/Dreams
___ Depression
___ Irritability/Anger
___ Fatigue
___ Poor memory
___ Weight loss or gain
___ Cold hands/feet
___ Sweating easily
___ Night sweats
___ Hot flashes

Gastrointestinal

___ Low appetite
___ Excessive appetite
___ Cravings
___ Gas or Bloating
___ Indigestion
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Laxative use

Cardiovascular/ Respiratory

___ Palpitations
___ Chest pain
___ Difficulty breathing
___ Blood clots
___ Swelling of hands/feet
___ Asthma
___ Shortness of breath
___ Difficult inhalation
___ Difficult exhalation
___ Cough

Skin/Hair

___ Acne/pimples
___ Eczema/Psoriasis
___ Itching or Hives
___ Hair loss
___ Easy bruising
___ Dry skin

Head: Ears, Nose, Throat

___ Sinus problems
___ Mucus
___ Grinding of teeth
___ Jaw pain
___ Dental problems
___ Vision problems
(describe)_____
_____
___ Headaches
___ Migraines

Genitourinary

___ Pain with urination
___ Blood in urine
___ Frequent urination
___ Urgent urination
___ Urinary incontinence
___ Incomplete urination
___ Kidney stones
___ Bedwetting
___ Bladder prolapsed

Psychological

___ Anger/Bad Temper
___ Anxiety
___ Depression
___ Stress
___ Worry
___ Grief
___ Considered suicide

Musculoskeletal

___ Joint pain/disorder
___ Muscle weakness
___ Neck pain
___ Shoulder pain
___ Back pain
___ Rib pain
___ Hip pain
___ Hand/wrist pain
___ Knee pain
___ Foot/ankle pain
___ Other joint/bone pain
(describe) _____
_____

Neurological

___ Numbness or tingling
___ Seizures
___ Tremors
___ Dizziness
___ Loss of balance
___ Poor memory

Lifestyle

___ Caffeine
___ Soda
___ Alcohol
___ Tobacco
___ Marijuana
___ Drugs
___ Sugar
___ Salt
___ Dieting
___ Exercise
___ Meditation
What type? _____
_____
How often? _____
_____